IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

September 7, 2007

Ms. Susan White
Creekside Hospice
1246 Yellowstone Avenue Suite C5
Pocatello, Idaho 83201

Provider #131550

Dear Ms. White:

On **July 10, 2007**, a Complaint Investigation was conducted at Creekside Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003083

Allegation: A hospice patient fell and sustained a head injury. She cut her head and needed immediate medical attention. Agency staff came to the facility and insisted the facility not allow the EMTs to transport the resident to the hospital.

Findings: An unannounced visit was made to the agency on July 9 and 10, 2007. Staff were interviewed. Clinical records and agency policies were reviewed.

One patient record identified a 71 year old female admitted to the hospice on 6/7/07 with a diagnosis of dementia. A direct care staff member at the Assisted Living Facility (ALF), where the patient resided, was interviewed at 2:10 PM on 7/9/07. She stated she was present when the patient fell on 6/21/07 onto a hard floor and struck her head loudly. She stated the patient received a laceration to the back of her head. She said she called 911 and notified the facility administrator who then notified the hospice. The hospice sent a Licensed Practical Nurse (LPN) to the ALF to examine the patient in order to determine whether or not the patient was injured and required medical care. However, the patient was taken to a local emergency room (ER) before the hospice nurse was able to examine her.

The patient's family did not wish her to be treated and communicated that to the ER. The patient was returned to the facility without treatment. Another LPN went to the facility after the patient's return from the ER on 6/21/07. Her progress note at 4:05 PM, stated the patient had a 1 inch long abrasion to the back of her head. No neurological check was documented. The section of the note labeled INTERVENTIONS was left blank. Under "Education" on the progress note, the LPN wrote "Discussed with (ALF) staff to notify hospice first with problems".

While it did not appear hospice staff attempted to prevent the patient from being taken to the ER at the time of the event, hospice staff did tell ALF staff to call them first in an emergency before calling 911. The hospice did not have a policy requesting to be called first. The hospice LPN overstepped her authority by giving this instruction to ALF staff. The case was complicated because the LPN who gave direction to ALF staff was also the patient's daughter in law so it was unclear if she was acting as the hospice nurse or the daughter in law. The hospice was cited at 42 CFR part 418.52 for failing to develop policies defining the role of LPNs and for failing to define conflict of interest for staff who provided hospice services to relatives. The hospice was also cited at 42 CFR part 418.82 for the lack of involvement by a registered nurse in this and other cases requiring professional judgement.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

GG/mlw

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July 25, 2007

Susan White, Administrator
Creekside Hospice
1246 Yellowstone Suite C5
Pocatello, Idaho 83201

RE: Creekside Hospice, provider #131550

Dear Ms. White:

This is to advise you of the findings of the Medicare survey, which was concluded at your facility on July 10, 2007.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 7, 2007**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

GG/mlw

Enclosures

Creekside Hospice

1246 Yellowstone Ave, Suite C5
Pocatello, Idaho 83201

August 6, 2007

Ms. Sylvia Creswell
Supervisor, Non-Long Term Care
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036

Dear Sylvia:

On 7/10/07, your survey team responded to a complaint and performed an investigation at the Creekside office. Although we are not pleased to have a complaint, we do appreciate the recommendations made by your staff. In response to their findings, we have made some policy changes and introduced an additional monitor to our quality chart audit.

Enclosed, please find the plan of correction and associated documents. If you have questions or require additional information, please contact me at 801-388-7610. Thank you for your consideration.

Sincerely,

Susan White

Susan White
Regional Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131550	A. BUILDING _____ B. WING _____	C 07/10/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HOSPICE	1246 YELLOWSTONE AVENUE, SUITE C5 POCATELLO, ID 83201

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L 000	INITIAL COMMENTS The following deficencies were cited during the complaint investigation survey of your hospice. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Rae Jean McPhillips, RN, HFS Patrick Hendrickson, RN, HFS Acronyms used in this report include: ALF = Assisted Living Facility ER = Emergency Room LPN = Licensed Practical Nurse POC = Plan of Care RN = Registered Nurse	L 000		
L 108	418.52 GOVERNING BODY A hospice must have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and agency policies, it was determined the governing body failed to assume responsibility for determining, implementing and monitoring policies governing conflict of interest and the role of LPNs and RNs. This affected the care of 3 of 6 patients (#s 1, 3, 4) whose records were reviewed and potentially all hospice patients. The findings include: 1. Two of six sampled records reviewed (#s 1 and 4) contained documentation of patients who fell and then were examined by LPNs for injuries and treatment recommendations. They were not examined by RNs. In addition, Patient #3	L 108	**Tag: L108 Regulation: 418.52 Governing Body** On 8/1/2007, the hospice implemented policies to address professional boundaries, the role of RN's and LPN's, and medical emergencies (see attached). The policies were reviewed and approved on 7/31/07 by the interdisciplinary team responsible for quality and hospice policy. The hospice director then reviewed the new policies with the hospice staff on 7/31/2007 at a staff meeting. Beginning in August 2007, the quality improvement coordinator will begin a monthly monitor of medical records to ensure registered nurses are providing all necessary assessments, including those required for updating the plan of care and when the patient has had a significant change of condition, and that registered nurses are supervising the practice of licensed practical nurses. Audit findings will be communicated to the hospice director for appropriate follow up.	8/1/2007

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Susan White, Regional Administrator | 8/6/2007

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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L 108	Continued From page 1 received nursing visits for a 24 day interval (4/28-5/21/07) and a 19 day interval (5/24-6/11/07) without being assessed by an RN. (Refer to L191 for details of LPN visits to patients.) The Hospice Regional Administrator and the Clinical Director were interviewed together on 7/10/07 at 9:15 AM. Both stated no policy was in place defining the roles of the LPN or when the RN must assess patients to update their POCs. 2. Patient #1 was a 71 year old female admitted to the hospice on 6/7/07 with a diagnosis of dementia. She fell on 6/21/07 onto a hard floor and struck her head. She received a laceration to the back of her head. The facility called 911 and had the patient transported to a local ER. An LPN examined the patient following her return to the facility. Her progress note, at 4:05 PM, stated "Discussed with (ALF) staff to notify hospice first with problems" (before calling 911). The hospice did not have a policy regarding what to tell providers regarding calling 911 in case of an emergency. In addition, the LPN who examined Patient #1 after the fall was the patient's daughter in law. She had also provided hospice nursing visits to the patient on 3 other occasions (6/18, 6/22, and 6/25/07). The Clinical Director was interviewed on 7/10/07 at 9:15 AM. She stated that, as Patient #1's relative, the LPN did not want her mother in law to be taken to the hospital. It was not clear whether the LPN was acting in the role of the hospice nurse or the daughter in law when she told the ALF not to call 911. The Clinical Director stated the hospice did not have a conflict of interest policy to define what staff's role was when providing services to relatives.	L 108		

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L 191	418.82 NURSING SERVICES The hospice must provide nursing care and services by or under the supervision of a registered nurse. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and agency policies, it was determined the hospice failed to ensure nursing care and services were provided by or under the supervision of a registered nurse for 3 of 6 patients (#s 1, 3 and 4) whose records were reviewed. The findings include: 1. Staff A was observed at an ALF, where hospice patients resided, on 7/9/07 at 2 PM. She was observed to be wearing a smock which stated her first name and the title "RN". The smock also said Creekside Home Health, the hospice's sister company. When interviewed at 3:45 PM, Staff A stated she was actually an LPN and the hospice had made a mistake by providing her with the smock. The Hospice Regional Administrator was interviewed on 7/10/07 at 9:15 AM. She stated she thought Staff A was an RN because she had witnessed Staff A wearing the smock. Patient #1 was a 71 year old female admitted to the hospice on 6/7/07 with a diagnosis of dementia. A direct care staff member at the ALF where the patient resided was interviewed at 2:10 PM on 7/9/07. She stated she was present when the patient fell on 6/21/07 onto a hard floor and struck her head loudly. She stated the patient received a laceration to the back of her head. She said she notified the facility administrator who then notified the hospice. Staff A, an LPN, was sent by the hospice to the ALF to examine	L 191	**Tag: L191 Regulation: 418.82 Nursing Services** On 8/1/07, the hospice implemented a policy that addresses the role of RN's and LPN's (see attached). The policy was reviewed and approved on 7/31/07 by the interdisciplinary team responsible for quality and hospice policy. The hospice director reviewed the policy with the hospice staff on 7/31/2007 at a staff meeting. Beginning in August 2007, the quality improvement coordinator will begin a monthly monitor of medical records to ensure registered nurses are providing all necessary assessments, including those required for updating the plan of care and when the patient has had a significant change of condition, and that registered nurses are supervising the practice of licensed practical nurses. Audit findings will be communicated to the hospice director for appropriate follow up.	8/1/2007

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L 191	Continued From page 3 the patient in order to determine whether or not the patient was injured and required medical care. The patient was taken to a local ER before Staff A was able to examine her. Patient #1's family did not wish her to be treated and communicated that to the ER. The patient was returned to the facility without treatment. Another hospice LPN went to the facility after the patient's return from the ER on 6/21/07. Her progress note at 4:05 PM, stated the patient had a 1 inch long abrasion to the back of her head. No neurological check was documented. The section of the note labeled INTERVENTIONS was left blank. Under "Education" on the progress note, the LPN wrote "Discussed with (ALF) staff to notify hospice first with problems". No documentation was present in the record that an RN had examined the patient. The RN's role is to assess the patient and provide direction to the LPN. An RN did not assess the patient. Also, the hospice did not have a policy regarding notification of the hospice first regarding a patient injury. This was confirmed by the Regional Administrator and the Clinical Director on 7/10/07 at 9:15 AM. Both stated the ALF should follow its own policies regarding calling 911 in an emergency. The LPN was not authorized to direct ALF personnel to notify the hospice of a patient's injury prior to calling 911. 2. Patient #3 was a 75 year old male admitted to the hospice on 7/27/06 with diagnoses which included chronic heart failure and Parkinson's disease. Nurse's notes contained in the record documented, that from 4/28/07 to 6/11/07, the patient had been seen 21 times. An RN had performed a recertification assessment on 5/22/07. The remaining visits were conducted by	L 191		

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L 191	Continued From page 4 an LPN. There was no documentation in the record indicating that an RN assessed the patient or supervised the LPN who was providing care for the patient. 3. Patient #4 was a 94 year old female admitted to the hospice on 9/25/06 with a diagnosis of failure to thrive. An incident report documented that on 1/21/07, at 7:30 PM, the patient had fallen out of her wheelchair. The report said at 8:00 p.m. the hospice LPN had "assessed the patient" and had given instructions to apply ice to the patient's forehead. There was no documentation in the patient's record that the RN had assessed the patient's injury or had been advised of the fall. The hospice failed to ensure nursing care and services were provided by or under the supervision of a registered nurse. Further, the agency failed to insure that an RN assessed patients or had supervised the LPN who was providing care for patients.	L 191		